

CANCELLATION FORM

(Change in Family Status)



Employee Name	
Social Security Number	Effective Date of Change

Reason for Change

Marriage ☐ Divorce ☐ Birth or Adoption of Child ☐ Change in Spouse's Employment ☐ Open Enrollment ☐

Other ☐ If other, explain: _____

Coverage Request

None ☐ Self (\$50 per mo) ☐ Self + 1 Dependents (\$192 per mo) ☐ Self + 2 or more dependents (\$237 per mo) ☐

Name of Person to be Cancelled	Date of Birth	Address	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Relationship to Employee
Name of Person to be Cancelled	Date of Birth	Address	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Relationship to Employee
Name of Person to be Cancelled	Date of Birth	Address	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Relationship to Employee
Name of Person to be Cancelled	Date of Birth	Address	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Relationship to Employee
Name of Person to be Cancelled	Date of Birth	Address	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Relationship to Employee
Name of Person to be Cancelled	Date of Birth	Address	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Relationship to Employee

REASON FOR DECLINING COVERAGE

Covered under another insurance plan? ☐ Yes ☐ No If yes, name of Insured: _____

Other: _____

☐ **CANCELLATION OF DEPENDENTS ONLY**

- I authorize the City of Richardson to deduct my portion of the insurance premium from my gross pay on a before-tax basis. I understand that one-half of the monthly premium will be deducted every pay period. I understand and acknowledge that the information I have provided is true and accurate to the best of my knowledge.

☐ **WAIVER OF ALL COVERAGE**

- If this is waiver of all CORPlan coverage for employee and his/her dependents, I understand that by signing this waiver, I will no longer have medical/dental/prescription coverage through the City's group health insurance plan. Further, I understand that if I do not secure coverage through another means (i.e. independent healthcare coverage, group coverage through my spouse's employer) and incur a catastrophic health issue that I will have no medical/dental/prescription coverage to pay for my care.
- I consent to waive my coverage under the City of Richardson's group healthcare plan. Waiving my coverage means that dependent coverage under CORPlan is not available for my dependents.
- I further submit that I am not legally bound by court order or divorce decree to maintain coverage for my eligible dependent children.
- I understand that if I choose to re-enroll myself and/or dependent(s) I will have to experience another lifestyle change in accordance to the IRS 125 code.

Employee Signature	Date
	GWLA/EHS
	AS400 ABT
	AS400 INS.
	COBRA
	HIPAA